TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED	
		HAL017006	9. WING		04/23/2015
	ROVIDER OR SUPPLIER	201 MARY		STATE, ZIP CODE ELOW ROAD 7379	
IX4) ID PRIEFIX TAG	(SACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBC COMPLETE
C 000	Initial Comments		C 000		
C 111	This report is of a biennial construction survey done by Bob Getchell on April 23, 2015. This facility was first licensed or submitted as a Home for the Aged serving 19 residents on on March 9, 1973. Therefore the facility must meet the 1971 and the applicable portions of the 2005 Rules for the Licensing of Adult Care Homes, and, the 1967 North Carolina State Building Code, Group D, Institutional Unrestrained. Deficiencies were noted which will require a new plan of correction. 111 Must Have Current San. & Fire Safety Reports SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0302 DESIGN AND CONSTRUCTION(1) The facility shall have current sanitation and		C 111	construction MAY 27 RECEI	2015
	shall be maintained review. This Rule is not m. 1. Based on obsersanitation reports withe survey. Findings Include: The following reporting of the survey: building, b) Sanita Fire Marshalls Rep	fety inspection reports which in the home and available for et as avidenced by: vation, the current fire and vere not available at the time of the wore not available at the a) Sanitation report for the ation report for the lation, c) out, d) Fire Alarm Panel		completed	
C 126	Annual Test Repor		C 126		

vision of Health Service Regulation BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

FORM APPROVED

Division	of Health Service Re	egulation			
STAYEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED
	HAL017006		8. WING	77 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	04/23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY,	STAYE, ZIP CODE	
POOLE'S	REST HOME		JANE BIG	ELOW ROAD 27379	
(X4) ID PREFIX I'AG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
C 126	Continued From pa	ge 1	C 126		
	SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0305 PHYSICAL ENVIRONMENT (d) The requirements for the bedroom are: (9) Each resident bedroom shall be ventilated with one or more windows which are maintained operable and well lighted. The window area shall be equivalent to at least eight percent of the floor space and be provided with insect screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and This Rule is not met as evidenced by:				
	maintained in a safe that have broken gla This could affect all creating a hazard to Findings include the door has broken gla	following: a) The front exit ss. b) The window in the broken glass, c) The window		a) completed b) completed c) work in progress completed by the week of June 20	will be second
C 148	Corridors-Handrails	i	C 148	Meet of anise	:
	corridors at 36 inche	5 PHYSICAL		Completed	

This Rule is not met as evidenced by:

STATEMENT OF DEFICIENCIES			FORMAPPROVED
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	
		A. BUILDING: 01	COMPLETED
NAME OF PROPERTY OF	HAL017006	B. WING	
NAME OF PROVIDER OR SUPPLIER	STREET AL	ORESS, CITY, STATE, ZIP CODE	04/23/2015
POOLE'S REST HOME	201 MAR	Y JANE BIGELOW ROAD	
(X4) ID : SUMMARY STAT	1 MAGE STA	/ILLE, NC 27379	
PRIEFIX (EACH DESIDIEMOY	MURIT OF DEFICIENCIES		r
7AO REGULATORY OF LS	C IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A	
C 148 Continued From pag	10.2	DEFICIENCY)	PPROPRIATE DAYS
		C 148	
are coming loose. The by exposing them to			
b) The handrail is co near the water cooler	ming loose in the corridor on the left hall,	Completed	
C 189 Building Equipment Ma		189	
SECTION .0300 - PHY 10A NCAC 13F .0311 REQUIREMENTS (a) The building and all mechanical, and plumb care home shall be mail operating condition, (k) This Rule shall appl facilities with the exception	OTHER I fire safety, electrical, ing equipment in an adult intained in a safe and y to new and existing		
This Rule is not met as a 1. Based on observation protection equipment was safe manner. This would not defecting smoke and Findings Include the follow a. The heat detector in roc wires. b) The Fire Alarm no power and was not functional functional formula to the following started immediately on 4-24-15 in supply was replaced that means returned to normal functions.	the building fire and maintained in a effect all residents by activating the fire alarm. Ving: Om 2 is hanging by the Panel indicated it had etioning. (Fire Watch 3-15. Interview with indicated a power	a) work in progress; completed by first June 2015 b) complete	will be Week of
earth Service Regulation			ı
lealth Service Regulation M			. 1

Obviolen of Health	Secules B	aculation			FORMAPPROVED
Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CONRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(XX) DAYE SURVEY COMPLETED	
• .		HAL017006	B. WING		04/23/2015
NAME OF PROVIDER OF		201 MARY	ODRESS, CITY, STATE, ZIP CODE Y JANE BIGELOW ROAD VILLE, NC 27379		
DREEK IBAC	HIDEF/CIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 189 Continue	d From pa	ge 3	C 189		
equipme This wou shock ha Findings Electrica Room P has an o 7 has ou 10 has a outlet. f) an open 3. Based maintaine did not cl smoke a staff by n compartr Findings Room co not latch, d/agging has a dai Room 10 frame, o door, f) door, g) door. 4. Based signage a maintaine residents emergen	nt was not all effect all zard. Include the Panel in the Panel in the Elect expans ground promise complete complete complete for a safe on observation door the Floor was a color Panel effect of the Panel e	vation, the building electrical maintained in a safe manner. I residents by presenting a electronic following: a following: a following: a following: a following: a following: a following: b blocked, b) extension cords, c) Room P sion devices in use, d) Room ion devices in use, e) Room programmer of inside the rical Panel in the Pantry has realing live contacts. A sation, the facility was not a manner by having doors that etely in order to contain a could affect all residents and right of origin. I following: a following: a following: a) The Dining is dragging the floor and will 4 has a corridor door and will 4 has a corridor door ith a loose knob, d) rridor door scrubbing the has a padlock on the closet as a padlock on the clo		a) completed b) completed on s c) completed on s e) completed on s e) completed on s e) completed on s e) completed by the s of June 2015. b) work in progress in completed by the completed by completed completed by completed by completed c	site site site seted swill be second week will be condweek will be

Division of Health Service I	Regulation			FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G: 01	(X3) DATE SURVEY COMPLETED
* , '-	HAL017006	B. WING _		04/23/2015
POOLE'S REST HOME 201 MARY			, STATE, ZIP CODE SELOW ROAD 27379	1 04/23/2015
PRÉFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JUD BE COMPLETE
c) The Exit sign is d) Evacuation plan 300 Hall and do no routes due to the o better indicate eva e) Exit sign in kitch backup. f) There is no FDC 5. Based on obser protection equipme safe manner. This not being available alarm. Findings include the a. The Fire Extingue monthly checks are fixtures were not me This would effect al to a fall hazard. Findings include the a. The Mens bathro from the floor. 7. Based on obser maintained in a safe of oxygen cylinders, residents by potenti from a ruptured cylin	missing at the back Exit door, missing at the left Exit door, in sare improperly displayed on a clearly indicate evacuation orientation. Orient plans to cuation routes, then is not working on battery is sign. Vation, the building fire and was not maintained in a would effect all residents by upon activation of the fire and being done per NFPA 10. I residents by exposing them a following: or has a toilet coming loose wation, the building was not a manner by improper storage. This would effect all ally exposing them to hazards		Tyr Fyghters Were and Stated that fix the deficure a) completed	contacted they would
unsecured oxygen of	rollowing: a) There is an eylinder in the staff office, b) of oxygen cylinders in Room		completed; oxyger	ntanks ud

PRINTED: 05/14/2015 FORM APPROVED

Division of	Health Service R	equiation			FORM APPROVE
STATEMENT OF AND PLAN OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	IX21 MUL	TIPLE CONSTRUCTION	
AND FDIN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILO		(X3) DATE SURVEY COMPLETED
					00/// 22/20
		HAL017006	B WING		
NAME OF PRO	VIDER OR SUPPLIER	STREET	DEWINE OF	Y. STATH, ZIP CODE	04/23/2015
POOLE'S RE	TI LIGARE			IGELOW ROAD	
POOLES NE	STHOME	YANGEY	VILLE, NO	27970	
(X4) ID ·	SUMMARY STA	TEMENT OF DEFICIENCIES			
PREFIX TAG	REGULATORY OR LE	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE COLUMN
C 189 ' Co	ntinued From pag	ge 5	C 169		
8. equipy: res into Find a. I fauc with C 191 Unv SEC 10A REC (b) main winte follow appli (2) I porta : (k) T facility which This : 1. B main prohib effect hazar	Based on observationment was not reallowing cross colidents by potential the potable water dings Include: In the Mop Room bet of the Utility silla vacuum breakter of the State of the shall be a hattan 75 degrees of the shall apply to shall apply to shall apply to shall not apply to s	ation, the building plumbing maintained in a safe manner needs. This would effect ali ally siphoning waste water or system. a hose is attached to the nk which is not equipped er. Elec. Heaters Prohibited YSICAL PLANT OTHER neating system sufficient to F (24 degrees C) under ns. In addition, the pheaters and cooking ning room heaters and existing potion of Paragraph (e) to new and existing potion of Paragraph (e) to existing facilities. Is evidenced by: ion, the building was not panner by allowing in the facility. This would exposing them to a fire	C 191	completed; hose	
				completed mostle	2